



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, contact Moda Health at [www.modahealth.com](http://www.modahealth.com) or by calling 1-855-425-4543. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms, see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary](http://www.healthcare.gov/sbc-glossary) or call 1-855-425-4543 to request a copy.

| Important Questions   | Answers   | Why This Matters:  |
|---|---|--|
| <b>What is the overall <a href="#">deductible</a>?</b>                                | For Tier I (Salem Health Hospitals & Clinics and facilities): None; for Tier II (Connexus network): \$750 individual / \$1,500 family; for Tier III (Connexus network): \$1,500 individual / \$3,000 family; for Tier IV ( <a href="#">out-of-network providers</a> ) : \$1,500 individual / \$3,000 family.                                | Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .   |
| <b>Are there services covered before you meet your <a href="#">deductible</a>?</b>    | Yes. Examples of some services: Tier II and Tier III <a href="#">preventive care</a> , most urgent care facility charges, office visits for outpatient behavioral health services, as well as Tier II and Tier III diabetes services, ambulance, and prescription medications are covered before you meet your <a href="#">deductible</a> . | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .  |
| <b>Are there other <a href="#">deductibles</a> for specific services?</b>             | No.   | You don't have to meet <a href="#">deductibles</a> for specific services.  |
| <b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b> | For Tier I \$2,500 individual / \$5,000 family in a calendar year; for Tier II \$3,500 individual / \$7,000 family; for Tier III \$5,900 individual / \$11,800 family; for Tier IV ( <a href="#">out-of-network providers</a> ) \$5,900 individual / \$11,800 family.   | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.  |
| <b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>               | <a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, expenses incurred due to brand substitution and health care this <a href="#">plan</a> doesn't cover.  | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .  |
| <b>Will you pay less if you use a <a href="#">network provider</a>?</b>               | Yes. See <a href="http://www.modahealth.com">www.modahealth.com</a> or call 1-855-425-4543 for a list of <a href="#">network providers</a> .  | You pay the least if you use a provider in Tier I (Salem Health Hospitals & Clinics and facilities). You pay more if you use a provider in Tier II or Tier III (Connexus network). You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |

| Important Questions  | Answers | Why This Matters:  |
|--|---------|--|
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ? | No.     | You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> . |

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

| Common Medical Event                                   | Services You May Need  | What You Will Pay |  |  |   | Limitations, Exceptions, & Other Important Information   |
|--|--|-------------------|--|--|---|--|
|  |  | Tier I Provider   | Tier II Provider   | Tier III Provider  | Tier IV Provider  |  |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness                           | No charge         | 10% <a href="#">coinsurance</a>  | 20% <a href="#">coinsurance</a>  | 40% <a href="#">coinsurance</a>   | None.  |
|  | <a href="#">Specialist</a> visit   | No charge         | \$20 <a href="#">copay</a> /visit, no <a href="#">deductible</a> for acupuncture, spinal manipulation and massage therapy<br>10% <a href="#">coinsurance</a> for all other visits and office services other than outpatient surgery and x-rays and lab tests | \$20 <a href="#">copay</a> /visit, no <a href="#">deductible</a> for acupuncture, spinal manipulation and massage therapy<br>20% <a href="#">coinsurance</a> for all other visits and office services other than outpatient surgery and x-rays and lab tests | 40% <a href="#">coinsurance</a> , no <a href="#">deductible</a> for acupuncture, spinal manipulation and massage therapy<br>40% <a href="#">coinsurance</a> for all other visits and office services other than outpatient surgery and x-rays and lab tests | Office visits by chiropractors, naturopathic physicians and acupuncturists are considered as specialist visits unless they are listed as PCPs in the network. 20 visits per calendar year maximum for acupuncture care. 20 visits per calendar year maximum for spinal manipulations. \$1,000 per calendar year maximum for massage therapy. |
|  | <a href="#">Preventive care</a> / <a href="#">screening</a> / immunization | No charge         | 10% <a href="#">coinsurance</a> for tobacco supplies<br>No charge for other services.  | 10% <a href="#">coinsurance</a> for tobacco supplies<br>No charge for other services.  | 40% <a href="#">coinsurance</a>   | You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.  |
| If you have a test                                     | <a href="#">Diagnostic test</a> (x-ray, blood work)                        | No charge         | 10% <a href="#">coinsurance</a>  | 20% <a href="#">coinsurance</a>  | 40% <a href="#">coinsurance</a>   | Includes other tests such as EKG, allergy testing and sleep study. Some services may have a different <a href="#">copay</a> / <a href="#">coinsurance</a> .  |
|  | Imaging (CT/PET scans, MRIs)   | No charge         | 10% <a href="#">coinsurance</a>  | \$100 <a href="#">copay</a> /visit, then 20% <a href="#">coinsurance</a> outpatient<br>20% <a href="#">coinsurance</a> inpatient   | \$100 <a href="#">copay</a> /visit, then 40% <a href="#">coinsurance</a> outpatient<br>40% <a href="#">coinsurance</a> inpatient  | Some services may have a different <a href="#">copay</a> / <a href="#">coinsurance</a> . <a href="#">Preauthorization</a> is required for many services. Failure to obtain <a href="#">preauthorization</a> results in denial.   |

| Common Medical Event   | Services You May Need | What You Will Pay   |  |   | Limitations, Exceptions, & Other Important Information  |
|--|-----------------------|---|--|---|---|
|  |                       | Tier I Provider   | Tier II Provider   | Tier III Provider   |   |
| <p><b>If you need drugs to treat your illness or condition</b><br/> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.modahealth.com/pdl">www.modahealth.com/pdl</a></p> | Value                 | \$2 <a href="#">copay</a> for 30-day supply retail / \$6 <a href="#">copay</a> for 90-day supply retail and mail order  | \$2 <a href="#">copay</a> for 30-day supply retail<br>No <a href="#">deductible</a>                                    | 50% <a href="#">coinsurance</a> for 30-day supply retail<br>No <a href="#">deductible</a> | Tier I - Salem Health and mail order pharmacies   |
|  | Select                | 25% <a href="#">coinsurance</a><br>\$5 minimum / \$25 maximum per prescription retail and mail order  | 35% <a href="#">coinsurance</a> , \$15 minimum / \$25 maximum per prescription retail<br>No <a href="#">deductible</a> | 50% <a href="#">coinsurance</a> per prescription retail<br>No <a href="#">deductible</a>  | Tier II - ArrayRx Core Network<br><br>Tier III – other retail pharmacies  |
|  | Preferred             | 30% <a href="#">coinsurance</a><br>\$5 minimum / \$75 maximum per prescription retail and mail order  | 40% <a href="#">coinsurance</a> , \$15 minimum / no maximum per prescription retail<br>No <a href="#">deductible</a>   | 50% <a href="#">coinsurance</a> per prescription retail<br>No <a href="#">deductible</a>  | Covers Tier I retail and mail order - up to a 90-day supply per prescription; Tier II and Tier III retail - up to a 30-day supply per prescription. <a href="#">Preauthorization</a> may be required. Mail order at a Moda designated mail order pharmacy only. |
|  | Non-Preferred         | 50% <a href="#">coinsurance</a><br>\$5 minimum / no maximum per prescription retail and mail order  | 50% <a href="#">coinsurance</a> , \$15 minimum / no maximum per prescription retail<br>No <a href="#">deductible</a>   | 50% <a href="#">coinsurance</a> per prescription retail<br>No <a href="#">deductible</a>  | Covers up to a 30-day supply specialty. <a href="#">Preauthorization</a> may be required. Moda designated pharmacy only.  |
|  | Specialty             | 25% <a href="#">coinsurance</a><br>\$5 minimum / \$25 maximum for select<br>30% <a href="#">coinsurance</a><br>\$150 maximum per prescription for preferred;<br>50% <a href="#">coinsurance</a> for non-preferred | Not covered  | Not covered   | Cost Sharing for anticancer medication is same as any other medication.<br><br>\$35 maximum cost share 30-day supply and \$105 maximum cost share 90-day supply for insulin, <a href="#">deductible</a> does not apply.   |

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.modahealth.com](http://www.modahealth.com).

| Common Medical Event                    | Services You May Need                            | What You Will Pay  |  |  |   | Limitations, Exceptions, & Other Important Information   |
|---|--|--|--|--|---|--|
|   |  | Tier I Provider  | Tier II Provider   | Tier III Provider  | Tier IV Provider  |  |
| If you have outpatient surgery          | Facility fee (e.g., ambulatory surgery center)   | No charge  | 10% <a href="#">coinsurance</a>  | 20% <a href="#">coinsurance</a>  | 40% <a href="#">coinsurance</a>   | Additional Cost Tier services require a \$100 <a href="#">copay</a> or a \$500 <a href="#">copay</a> , then 20% <a href="#">coinsurance</a> for Tier II and Tier III or 40% <a href="#">coinsurance</a> for Tier IV. <a href="#">Preauthorization</a> may be required. Failure to get <a href="#">preauthorization</a> results in denial.                  |
|   | Physician/surgeon fees                           | No charge  | 10% <a href="#">coinsurance</a>  | 20% <a href="#">coinsurance</a>  | 40% <a href="#">coinsurance</a>   |  |
| If you need immediate medical attention | <a href="#">Emergency room care</a>              | Facility fee: \$250 <a href="#">copay</a> /visit<br>Provider fee: No charge  | Facility fee: \$250 <a href="#">copay</a> /visit<br>Provider fee: No charge  | Facility fee: \$250 <a href="#">copay</a> /visit<br>Provider fee: No charge  | Facility fee: \$250 <a href="#">copay</a> /visit<br>Provider fee: No charge   | <a href="#">Copay</a> waived if hospital admission immediately follows.  |
|   | <a href="#">Emergency medical transportation</a> | 10% <a href="#">coinsurance</a> , no <a href="#">deductible</a>  | 10% <a href="#">coinsurance</a> , no <a href="#">deductible</a>  | 10% <a href="#">coinsurance</a> , no <a href="#">deductible</a>  | 10% <a href="#">coinsurance</a> , no <a href="#">deductible</a>   | None.  |
|   | <a href="#">Urgent care</a>                      | No charge for visits related to mental health/substance abuse; No charge for virtual care visits by Salem Health <a href="#">providers</a> ; \$20 <a href="#">copay</a> / visit for all other visits | No charge for visits related to mental health/substance abuse; \$40 <a href="#">copay</a> /visit, no <a href="#">deductible</a> for all other visits | No charge for visits related to mental health/substance abuse; \$50 <a href="#">copay</a> /visit, no <a href="#">deductible</a> for all other visits | No charge for visits related to mental health/substance abuse; 40% <a href="#">coinsurance</a> for all other visits | None.  |
| If you have a hospital stay             | Facility fee (e.g., hospital room)               | No charge  | 10% <a href="#">coinsurance</a>  | 20% <a href="#">coinsurance</a>  | 40% <a href="#">coinsurance</a>   | Additional Cost Tier services require a \$100 <a href="#">copay</a> or a \$500 <a href="#">copay</a> , then 20% <a href="#">coinsurance</a> for Tier II and Tier III or 40% <a href="#">coinsurance</a> for Tier IV. <a href="#">Preauthorization</a> is required for many services. Failure to obtain <a href="#">preauthorization</a> results in denial. |
|   | Physician/surgeon fees                           | No charge  | 10% <a href="#">coinsurance</a>  | 20% <a href="#">coinsurance</a>  | 40% <a href="#">coinsurance</a>   |  |

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.modahealth.com](http://www.modahealth.com).

| Common Medical Event  | Services You May Need                     | What You Will Pay |  |  |   | Limitations, Exceptions, & Other Important Information   |
|---|---|-------------------|--|--|---|--|
|   |   | Tier I Provider   | Tier II Provider   | Tier III Provider  | Tier IV Provider  |  |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                       | No charge         | No charge for office visits<br>10% <a href="#">coinsurance</a> for other outpatient services.          | No charge for office visits<br>10% <a href="#">coinsurance</a> for other outpatient services.          | No charge for office visits<br>40% <a href="#">coinsurance</a> for other outpatient services. | Plan <a href="#">coinsurance</a> may apply to some services.   |
|   | Inpatient services                        | No charge         | No charge for Residential Treatment Programs<br>10% <a href="#">coinsurance</a> for all other services | No charge for Residential Treatment Programs<br>10% <a href="#">coinsurance</a> for all other services | 40% <a href="#">coinsurance</a>   | <a href="#">Preauthorization</a> is required. Failure to obtain <a href="#">preauthorization</a> results in denial.  |
| If you are pregnant   | Office visits                             | No charge         | 10% <a href="#">coinsurance</a>  | 20% <a href="#">coinsurance</a>  | 40% <a href="#">coinsurance</a>   | <a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">copay</a> , <a href="#">coinsurance</a> or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).   |
|   | Childbirth/delivery professional services | No charge         | 10% <a href="#">coinsurance</a>  | 20% <a href="#">coinsurance</a>  | 40% <a href="#">coinsurance</a>   |  |
|   | Childbirth/delivery facility services     | No charge         | 10% <a href="#">coinsurance</a>  | 20% <a href="#">coinsurance</a>  | 40% <a href="#">coinsurance</a>   |  |
| If you need help recovering or have other special health needs            | <a href="#">Home health care</a>          | No charge         | 10% <a href="#">coinsurance</a>  | 10% <a href="#">coinsurance</a>  | 40% <a href="#">coinsurance</a>   | Calendar year maximum of 100 visits.   |
|   | <a href="#">Rehabilitation services</a>   | No charge         | 10% <a href="#">coinsurance</a>  | 20% <a href="#">coinsurance</a>  | 40% <a href="#">coinsurance</a>   | Calendar year maximum of 60 visits each for physical therapy, occupational therapy and speech and hearing therapy except for treating mental health conditions. Services for neurodevelopmental disorders or developmental delays related to a neurogenic condition are covered. <a href="#">Preauthorization</a> may be required. Failure to obtain <a href="#">preauthorization</a> results in denial. |
|   | <a href="#">Habilitation services</a>     | No charge         | 10% <a href="#">coinsurance</a>  | 20% <a href="#">coinsurance</a>  | 40% <a href="#">coinsurance</a>   |  |

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.modahealth.com](http://www.modahealth.com).

| Common Medical Event   | Services You May Need                     | What You Will Pay |                                 |                                 |                                 | Limitations, Exceptions, & Other Important Information   |
|--|---|-------------------|---------------------------------|---------------------------------|---------------------------------|--|
|  |   | Tier I Provider   | Tier II Provider                | Tier III Provider               | Tier IV Provider                |  |
| If you need help recovering or have other special health needs | <a href="#">Skilled nursing care</a>      | N/A               | 10% <a href="#">coinsurance</a> | 10% <a href="#">coinsurance</a> | 40% <a href="#">coinsurance</a> | Calendar year maximum of 120 days  |
|  | <a href="#">Durable medical equipment</a> | No charge         | 10% <a href="#">coinsurance</a> | 10% <a href="#">coinsurance</a> | 40% <a href="#">coinsurance</a> | Includes supplies and prosthetics. <a href="#">Preauthorization</a> may be required. Failure to obtain <a href="#">preauthorization</a> results in denial. |
|  | <a href="#">Hospice services</a>          | No charge         | 10% <a href="#">coinsurance</a> | 10% <a href="#">coinsurance</a> | 40% <a href="#">coinsurance</a> | None.  |
| If your child needs dental or eye care                         | Children's eye exam                       | No charge         | No charge                       | No charge                       | 40% <a href="#">coinsurance</a> | Preventive vision exam limited for children age 3-5. Eye exams are not covered for other ages.   |
|  | Children's glasses                        | Not covered       | Not covered                     | Not covered                     | Not covered                     | None.  |
|  | Children's dental check-up                | Not covered       | Not covered                     | Not covered                     | Not covered                     | None   |

#### Excluded Services & Other Covered Services:

| Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)  |   |  |
|--|---|--|
| <ul style="list-style-type: none"> <li>• Cosmetic surgery, except as required for certain situations</li> <li>• Dental care (Adult), except for accident related injuries</li> <li>• Infertility treatment (except for diagnostic visits)</li> </ul> | <ul style="list-style-type: none"> <li>• Long-term care</li> <li>• Naturopathic supplies</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul> | <ul style="list-style-type: none"> <li>• Private-duty nursing</li> <li>• Routine eye care (Adult)</li> <li>• Routine foot care, except for diabetes</li> <li>• Weight loss programs</li> </ul> |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.) |  |  |
|--|--|--|
| <ul style="list-style-type: none"> <li>• Abortion</li> <li>• Acupuncture</li> </ul>  | <ul style="list-style-type: none"> <li>• Bariatric surgery</li> <li>• Chiropractic care</li> </ul> | <ul style="list-style-type: none"> <li>• Hearing aids</li> </ul> |

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or <http://www.dol.gov/ebsa/healthreform> for group health coverage subject to ERISA, the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov) for non-federal governmental group health plans, and the Oregon Division of Financial Regulation at 1-888-877-4894 or [www.dfr.oregon.gov](http://www.dfr.oregon.gov) for Church plans. Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.modahealth.com](http://www.modahealth.com).

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: Moda Health at 1-855-425-4543. For group health coverage subject to ERISA, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Additionally, a consumer assistance program can help you file your [appeal](#). Contact the Oregon Division of Financial Regulation at 1-888-877-4894 or [www.dfr.oregon.gov](http://www.dfr.oregon.gov).

**Does this plan provide Minimum Essential Coverage? Yes.**

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

**Does this plan meet the Minimum Value Standards? Yes.**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 888-786-7461.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 888-873-1395.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 888-873-1395.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 888-873-1395.

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost-sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$750
- [Specialist coinsurance](#) 10%
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 10%

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
[Diagnostic tests](#) (*ultrasounds and blood work*)  
[Specialist](#) visit (*anesthesia*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$750          |
| <a href="#">Copayments</a>        | \$0            |
| <a href="#">Coinsurance</a>       | \$1,200        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$50           |
| <b>The total Peg would pay is</b> | <b>\$2,000</b> |

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$750
- [Specialist coinsurance](#) 10%
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 10%

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)  
[Diagnostic tests](#) (*blood work*)  
[Prescription drugs](#)  
[Durable medical equipment](#) (*glucose meter*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$700          |
| <a href="#">Copayments</a>        | \$60           |
| <a href="#">Coinsurance</a>       | \$1,700        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$2,480</b> |

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$750
- [Specialist coinsurance](#) 10%
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 10%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$750          |
| <a href="#">Copayments</a>        | \$300          |
| <a href="#">Coinsurance</a>       | \$100          |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$1,150</b> |

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.